Disability Insurance Claim Form

UNITED SECURITY
HEALTH AND CASUALTY INSURANCE COMPANY
6640 S. Cicero Ave., Bedford Park, Illinois 60638
708/475-6100 800/875-4422 F: 708/475-6120

Patient & Insured (Subscriber) Information

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLACK LUNG OTHER ❑ (Medicare #) ❑ (Medicaid #) ❑ (Sponsor SSN) ❑ (VA File #) ❑ (SSN or ID) ❑ (SSN) ❑ (ID)		1a. Insured's I.D. Number (For Program in Item 1)
2. Patient's Name (Last Name, First Name, Middle Initial)	3. Patient's Birth Date MM DD YY Sex ❑ M ❑ F	4. Insured's Name (Last Name, First Name, Middle Initial
5. Patient's Address (No. Street)	6. Patient Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other	7. Insured's Address (No. Street)
City State	8. Patient Status City State ❑ Single ❑ Married ❑ Other	City State
Zip Code Telephone (Include Area Code)	❑ Employed ❑ Full-time Student ❑ Part-time Student	Zip Code Telephone (Include Area Code)
9. Other Insured's Name (Last Name, First Name, Middle Initial)	10. Is Patient Condition related to	11. Insured's Policy Group or FECA Number
a. Other Insured's Policy or Group Number	a. Employment? (Current or Previous) ❑ Yes ❑ No	a. Insured's Date of Birth MM DD YY Sex ❑ M ❑ F
b. Other Insured's Date of Birth MM DD YY Sex ❑ M ❑ F	b. Auto Accident? Place (State) ❑ Yes ❑ No	b. Employer's Name or School Name
c. Employer's Name or School Name	c. Other Accident? ❑ Yes ❑ No	c. Insurance Plan Name or School Name
d. Insurance Plan Name or School Name	10d. Reserved for Local Use	d. Is there another Health Benefit Plan? ❑ Yes ❑ No If yes, return to and complete item 9 a. - d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment below. Signed Date		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signed

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of Current MM DD YY Illness (First Symptoms) or Injury (Accident) or Pregnancy (LMP)	15. If Patient has same or similar illness: Give first date: MM DD YY	16. Dates Patient unable to work in current occupation MM DD YY MM DD YY From: To:
17. Date Patient able to return to work	18. Dates of Total Disability From: Through:	Dates of Partial Disability From: Through:
21. Diagnosis or Nature of Illness or Injury (Related items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____		22. Was Laboratory work performed outside your office? ❑ Yes ❑ No Charges: 23. Reserved For Local Use

24. A Dates of Service From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D Procedures, Services or Supplies (Explain Unusual Circumstances) CPT HCPCS | MODIFIER	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local use

25. Federal Tax I.D. Number SSN ❑ EIN ❑	26. Patient's Account Number	27. Accept Assignments? For Govt. claims see back ❑ Yes ❑ No	28. Total Charge $	29. Amount Paid $	30. Balance Due $
31. Signature of Physician or supplier including degrees or credentials. (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signed Date	32. Name and Address of Facility where services were rendered (If other than home or Office)		33. Physician's or Supplier's Name, Address, Zip Code & Phone Number PIN# | GRP#		

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DISABILITY CLAIMANT'S STATEMENT AND AUTHORIZATION

Policyholder's Name: _____ Policy Number _____

Address: _____

Home Phone: _____ Date of Birth: _____

Occupation: _____

Employer' Name: _____

Employer's Address: _____ Employer's Phone Number: _____

1. CLAIM IS FOR: Accident ( ) Illness ( ) Date of accident or first sign of illness: _____

2. Nature of illness / injury: _____

3. If claim is for an accident, describe how and where it occurred: _____

IMPORTANT: IF THIS CLAIM IS DUE TO A VEHICLE ACCIDENT, PLEASE SUMIT A COPY OF THE POLICE REPORT

4. Has claim been made or will be made under any Worker's Compensation or Employers Liability Law? Yes ( ) No ( )

5. Were you hospitalized? Yes ( ) No ( ) If yes, give dates: from _____ to _____
Mo Day Year Mo Day Year

6. List all Doctors that you have seen for the treatment of this condition.
Name Address Date 1st Seen

_____

_____

_____

7. Have you ever had symptoms of this condition before? Yes ( ) No ( ) When? _____

8. Do you have DISABILITY insurance with any other Company? Yes ( ) No ( ) If yes, provide:
Name of Company Policy Number(s)

_____

_____

9. Date you stopped working due to disability _____ Date you returned, or will return to work _____

10. Are you confined (restricted by Dr.'s orders) to your home? Yes ( ) No ( )

11. Average monthly earnings? $ _____ 12. List job duties _____

IMPORTANT: PLEASE SUBMIT COPIES OF YOUR LATEST W-2 FORMS AND 1040 TAX FILINGS

EMPLOYER'S STATEMENT: Must be completed for disability benefits:

1. Date of first absence due to disability _____ Date Employee returned, or will return to work _____

2. Date hired _____ Date of termination if Employee is terminated _____

3. Has a claim or will a claim be made for Worker's Compensation Benefit's? Yes ( ) No ( )
If yes, what is the status of the claim? _____

4. To your knowledge is the Employee entitled to any disability benefit other than the U.S.L.& H. policy or Worker's Compensation?
Yes ( ) No ( ) If yes, who is the provider _____

5. Will you provide "light duty" if employee is released with restrictions? Yes ( ) No ( )

Name of Employer _____ Phone Number of Employer _____

Authorized Signature _____ Title or Position _____ Date: _____

VERIFICATION AND AUTHORIZATION

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge. By this form (or copy), I authorize any medical practitioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medical or medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of me or my health, to give United Security Life and Health Insurance Company, its reinsurers, affiliates, or business associates, any such information which shall include, but not be limited to, Alcohol or Drug abuse treatment, Mental Health diagnosis and treatment, Pharmacy prescriptions, HIV testing and treatment, Sexually Transmitted Disease (STD) testing and treatment, Genetic testing, Sickle Cell testing and treatment, lab data, and diagnostic testing. Any information obtained will not be released by the company to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal service in connection with my claim, or as may be otherwise lawfully required or as I may further authorize. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall be valid for twelve months from the date shown below. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to United Security Life and Health Insurance Company, 6640 South Cicero Avenue, Bedford Park, Illinois 60638, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or the extent that United Security Life and Health Insurance Company has legal right to contest a claim under an insurance policy or to contest the policy itself. A photographic copy of this authorization and aknowlegdement shall be as valid as the original.

_____ _____

Claimant's / Representative's Signature Representative's Relationship Date